



OLS USE ONLY

PATIENT INFORMATION

PATIENT ID (Chart #, etc.)			MAX. 17 CHARACTERS
LAST NAME	FIRST NAME	MI	
DATE OF BIRTH		SS# (last 4 only, optional)	
COUNTY OF RESIDENCE		SEX <input type="checkbox"/> Female <input type="checkbox"/> Male	
STREET ADDRESS			
CITY	STATE	ZIP	
PATIENT PHONE NO. (optional)			

FACILITY NAME		
MAILING ADDRESS		
CITY	STATE	ZIP
COUNTY		
ATTENTION TO		
PHONE NO.		
FAX NO.		

COMMENTS:

❑ UNSAT | Reason:

ACC:

☐ UNRELIABLE | Reason:

DE:

☐ SATISFACTORY

CKD:

SITE/SOURCE OF SPECIMEN:

<input type="checkbox"/> Blood	<input type="checkbox"/> Sputum
<input type="checkbox"/> Cellulose tape mount	<input type="checkbox"/> Sputum, induced
<input type="checkbox"/> CSF	<input type="checkbox"/> Stool
<input type="checkbox"/> Nasopharyngeal	<input type="checkbox"/> Stool, bloody
<input type="checkbox"/> Rectal	<input type="checkbox"/> Throat
<input type="checkbox"/> Serum	<input type="checkbox"/> Urethra
<input type="checkbox"/> Serum, acute	<input type="checkbox"/> Urine
<input type="checkbox"/> Serum, convalescent	
<input type="checkbox"/> Wound	Location:
<input type="checkbox"/> Bronchial	Specify:
<input type="checkbox"/> Tissue	Specify:
<input type="checkbox"/> Fluid	Specify:
<input type="checkbox"/> Other	Specify:

BACTERIOLOGY		MYCOBACTERIOLOGY	
<input type="checkbox"/>	Referred Culture	<input type="checkbox"/>	Culture/Smear
<input type="checkbox"/>	Pertussis culture / PCR	<input type="checkbox"/>	TB ID/Confirmation
<input type="checkbox"/>	Enteric (stool in Cary-Blair)	<input type="checkbox"/>	MOTT Identification
<input type="checkbox"/>	Gonorrhea culture	Suspected Organism:	
<input type="checkbox"/>	Gonorrhea smear		
<input type="checkbox"/>	Unknown bacteriology ID	Date growth appeared:	
Suspected Organism (s):		Patient taking TB drugs?	
		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		Date Started:	

☐ Influenza RT-PCR

Submitted for:

☐ Surveillance (Sentinel)

☐ Other *(note in Comments)*

☐ Outbreak

If outbreak . . .

☐ School

☐ Nursing Home

☐ Other

☐ Respiratory Virus Panel*

Was sample frozen? ☐ Yes ☐ No

☐ Norovirus RT-PCR*

DIDE Contact Name:

(REQUIRED FOR OUTBREAKS - OBTAIN FROM DIDE)

<input type="checkbox"/>	Fecal Parasite Exam 10% formalin
<input type="checkbox"/>	Fecal Parasite Exam PVA
<input type="checkbox"/>	Pinworm Exam

 Referred Culture

* Testing performed on outbreak specimens ONLY.

DIDE = Division of Infectious Disease Epidemiology

FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY MAY RESULT IN DELAYED TEST RESULTS

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